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STATE OF WASHINGTON  
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IN THE SUPREME COURT  
OF THE STATE OF WASHINGTON

BY RONALD J. WINTER  
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OVERLAKE HOSPITAL ASSOCIATION and OVERLAKE HOSPITAL  
MEDICAL CENTER, Washington nonprofit corporations; and KING  
COUNTY PUBLIC HOSPITAL DISTRICT NO. 2, d/b/a EVERGREEN  
HEALTHCARE, a Washington Public Hospital District,

Appellants,

v.

DEPARTMENT OF HEALTH OF THE STATE OF WASHINGTON,

Respondent.

ANSWER OF OVERLAKE HOSPITAL ASSOCIATION AND  
OVERLAKE HOSPITAL MEDICAL CENTER; AND KING COUNTY  
PUBLIC HOSPITAL DISTRICT NO. 2, d/b/a EVERGREEN  
HEALTHCARE TO SWEDISH'S AND THE DEPARTMENT OF  
HEALTH'S PETITIONS FOR REVIEW

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ORIGINAL

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**A. IDENTITY OF ANSWERING PARTIES**

Then Answering Parties are Overlake Hospital Medical Center and Overlake Hospital Association (collectively “Overlake”) and King County Public Hospital District No. 2, d/b/a Evergreen Healthcare (“Evergreen”).

**B. SUMMARY OF THE CASE**

Overlake and Evergreen request that this Court deny discretionary review of *Overlake v. Dep’t of Health*, \_\_ Wn. App. \_\_\_, 200 P.3d 248 (2008) (attached hereto as Appendix A). The Court of Appeals clarified and corrected the Department of Health’s (the “Department’s”) misapplication of the methodology for determining when new outpatient operating rooms are needed in a geographic planning area (WAC 246-310-270(9), the “Methodology”) (Appendix B) and brought the Department’s interpretation of the Methodology in line with the Methodology’s plain language and the stated policy goals of the Legislature.

The Methodology contains the steps for calculating the future projected need for new operating rooms in Ambulatory Surgical Facilities (which require a certificate of need to operate) in a given health planning area. First, the Methodology determines the existing capacity of operating rooms in the particular planning area. WAC 246-310-270(9)(a). Second, it projects the number of surgeries to be performed in that planning area three years into the future. WAC 246-310-270(9) (b). Third, the existing

capacity is compared against the projected future need for surgeries to determine whether the existing capacity can meet the projected future need. WAC 246-310-270(9)(c).

The issue in this case was whether to use data from the same set of operating rooms when determining the existing capacity of the planning area and when projecting the future need for surgeries. Swedish and the Department argued for excluding operating rooms in private physicians' offices ("Exempt Surgical Facilities," which do not require a certificate of need) when calculating existing capacity, but including the surgeries performed in those operating rooms when projecting future need.

The Department's Final Order (the "Final Order") (attached hereto as Appendix C) correctly determined that the plain language of the Methodology did not distinguish between sets of operating rooms when determining existing capacity and projecting future need. CP 28, 29 (also AR 506-07), Appendix C, Paragraphs 2.7 – 2.8. The Final Order also correctly recognized that "[w]here the plain meaning of a provision is plain on its face, the court must give effect to that plain meaning as an expression of legislative intent." CP 28, Paragraph 2.7 – 2.8. However, the Final Order departed from the plain language of the rule, based on a selective reading of the statement of legislative intent in RCW 70.38.015(1) (2006). The Final Order illogically determined that current operating rooms in Ambulatory Surgical Facilities must be able to accommodate those surgeries currently performed in them, *as well as*

those surgeries performed in Exempt Surgical Facilities in private physicians' offices.

The Court of Appeals correctly held that this approach “will inevitably be biased toward need” for more operating rooms and found no support for this approach in the language of the Methodology itself. *Overlake*, 200 P.3d at 250. The Department had justified straying from the plain meaning of the Methodology based on a flawed policy argument, but the Court of Appeals correctly rejected this illogical approach, and held that:

[s]ound reasoning requires the concomitant inclusion or exclusion of exempt facilities [for both determining existing capacity and projecting of future need]. To do otherwise defies logic and the plain meaning of the language used throughout the pertinent WAC.

*Overlake*, 200 P.3d at 250.<sup>1</sup>

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<sup>1</sup> The Court of Appeals determined as follows:

Testimony at the administrative hearing indicated that the Department's rationale for this unsound practice lay in the Legislature's policy directive to provide “accessible” health care. But, access to health care, though important, was only one reason motivating the Legislature in creating the certificate of need program. The Legislature's primary purpose was to control costs by limiting competition. [Footnote 7 omitted.] The Legislature clearly enunciated its goals in its declaration of public policy:

That strategic health planning efforts must be supported by appropriately tailored regulatory activities that can effectuate the goals and principles of the statewide health resources strategy developed pursuant to chapter 43.370 RCW. The implementation of the strategy can promote, maintain, and assure the health of all citizens in the state, provide accessible health services, health manpower, health facilities, and other resources *while controlling increases in costs*, and recognize prevention as a high priority in health programs.[Footnote 8: RCW 70.38.015(1) (emphasis added by the Court of Appeals.)]

As the Supreme Court in *Saint Joseph Hospital v. Department of Health* noted:

In sum, the Court of Appeals decided this case based on the text of the Methodology itself and rejected the Department's flawed policy arguments for abandoning the plain language. The Court of Appeals did not change the Methodology for determining whether a need existed, or somehow limit the Department's authority to appropriately change health planning policy, it simply corrected the Department's application of its own regulation. The Court of Appeals correctly recognized that the Department is entitled to deference, but not when its "decision is based on an implausible interpretation of its regulations." *Overlake*, 200 P.3d at 248.

The Court of Appeals decision will not harm Washington's residents or its health care system, or somehow reduce patient choice. These arguments are red herrings that are unsupported by the record and should be disregarded. *Overlake* and *Evergreen* request that this Court deny *Swedish's* and the Department's petitions for direct review.

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While the Legislature clearly wanted to control health care costs to the public, equally clear is its intention to accomplish that control by limiting competition within the health care industry. The United States Congress and our Legislature made the judgment that competition had a tendency to drive health care costs up rather than down and government therefore needed to restrain marketplace forces. The means and end here are inextricably tied. [Footnote 9: 125 Wn.2d 733, 741, 887 P.2d 891 (1995).]

The formula as interpreted and applied here by the Department is not particularly helpful in achieving any of these goals as it results in a formula that is fundamentally unsound.

*Overlake*, 200 P.3d at 250.

C. ARGUMENT

1. No Issue of Substantial Public Interest Exists That Warrants Supreme Court Review.

The present case, like most cases published by the Court of Appeals, corrects and clarifies the law, but it does not reach the high threshold for Supreme Court review. Neither Swedish nor the Department identify an issue of “*substantial* public interest that *should be determined by the Supreme Court.*” RAP 13.4(b)(4) (emphasis added). The standard for discretionary review by this Court is markedly different than the standard used by the Court of Appeals when ruling on a motion to publish one of its decisions, which is whether an issue “of *general* public interest or importance” exists. RAP 12.3 (emphasis added).

Overlake and Evergreen moved the Court of Appeals to publish its decision in this case, in part, because it contained issues “of *general* public interest or importance.” RAP 12.3 (emphasis added). Other certificate of need matters are pending that depend on the outcome of the present case. However, this reasoning does not automatically justify review by the Supreme Court. If the standards in RAP 12.3 and RAP 13.4 were equivalent, as Swedish suggests, this Court would be bound to accept review of all published opinions of the Court of Appeals. This Court is obviously not so bound. This Court should deny Swedish’s and the Department’s petitions for review because this case does not meet the heightened standard of RAP 13.4(b)(4) for the reasons discussed below.

a. The Court of Appeals Applied the Correct Level of Deference to the Department.

Swedish and the Department claim that the Court of Appeals did not appropriately defer to the Department. This claim is wrong. The first sentence of the Court of Appeals' opinion recognizes that an agency is due deference is due by a reviewing court:

Although a high level of deference is accorded to an agency's determination under the Administrative Procedure Act, [footnote omitted] such deference will not lie where an agency's decision is based on an implausible interpretation of its regulations.

*Overlake*, 200 P.3d at 248.

This recognition of the correct level of deference due the Department is consistent with this Court's recent holdings on the subject. *See Univ. of Wash. Med. Ctr. v. Wash. State Dep't of Health*, 164 Wn.2d 95, 102, 187 P.3d 243 (2008) ("*The error of law standard permits this court to substitute its interpretation of the law for that of the agency*, but we accord substantial deference to the agency's interpretation, particularly in regard to the law involving the agency's special knowledge and expertise") (emphasis added); *Safeco Ins. Co. v. Meyering*, 102 Wn.2d 385, 392, 687 P.2d 195 (1984) (courts have the "ultimate responsibility to see that the rules are applied consistently with the policy underlying the statute.")

No deference to the Department's specialized knowledge is required here because the Methodology is a series of mathematical

calculations, which are described by a series of terms that can and should be used consistently throughout the Methodology, without any specialized knowledge of health planning. See *Mader v. Health Care Auth.*, 149 Wn.2d 458, 473, 70 P.3d 931 (2003); *Children's Hosp. and Med. Ctr. v. Dep't of Health*, 95 Wn. App. 858, 873, 975 P.2d 567 (1999). The doctrine of agency deference was never intended to be an excuse to avoid the well-established principles of statutory construction, particularly when, as here, the Department and Swedish are inappropriately using it as a shield to divert attention from their mathematically nonsensical application of the Methodology.

Swedish and the Department argue that deference means blind adherence to the Department's illogical interpretation of the Methodology. However, even with the appropriate deference to an agency's expertise, an agency must logically interpret its own regulations. See *White v. Salvation Army*, 118 Wn. App. 272, 277, 75 P.3d 990 (2003); *State v. McGinty*, 80 Wn. App. 157, 160, 906 P.2d 1006 (1995) ("Rules of statutory construction, which apply equally to administrative rules and regulations, require statutes to be given a rational, sensible construction"). Deference is not a rubber stamp of the Department's interpretation. An administrative interpretation of the law is accorded deference only according to "the validity of its reasoning." *White*, 118 Wn. App. at 277. No deference is given to an agency's interpretation of the law that is wrong. See *White*, 118 Wn. App. at 277.

Swedish is wrong that the Department's interpretation of the Methodology was consistent with the language of the regulation. The Department's Final Order uses the following illogical reasoning:

- The plain language of the Methodology requires including Exempt Surgical Facilities in the projection of future capacity under WAC 246-310-270(9)(b)(i) (the *need* side of the equation);
- The plain language of the *capacity* side of the equation also “appears to be all inclusive [of Exempt Surgical Facilities]” under WAC 246-310-270(9)(a)(iii);
- However, despite these accurate conclusions, a plain language reading of the *capacity* side of the equation under WAC 246-310-270(9)(a)(iii) should be abandoned in favor of a misguided interpretation of the legislative intent, as discussed above.

Final Order, pp 16-18, Appendix C.

No court should defer to the Department when, as in the present case, the Department had committed such a clear error by disregarding the plain language of its own rule.

b. The Court of Appeals Did Not “Infringe” on the Department’s Authority to Set Health Planning Policy.

The Court of Appeals corrected the Department's interpretation of the Methodology to bring it in line with the language of the Methodology itself and the stated policy of the Legislature. It did not infringe on the Department's authority over health planning policy. Nor did the Court of Appeals change the rules for approving ambulatory surgical facilities. Instead, the Court simply required the Department to adhere to its own

rules and the legislative policy of the certificate of need program, as has been recognized by this Court. *St. Joseph Hospital v. Dep't of Health*, 125 Wn.2d 733, 741, 887 P.2d 891 (1995).<sup>2</sup>

The Department retains full authority to engage in rulemaking, consistent with its legislative mandate and pursuant to the requirements of Washington's Administrative Procedure Act (the "APA"), chapter 34.05 RCW. If it wishes to adjust the Methodology, APA rulemaking is the proper route for it to do so.

c. Washington's Residents and Health Care System  
Will Not Be Harmed by the Court of Appeals  
Opinion.

Swedish dedicates a substantial part of its Petition for Review to hyperbolic and false arguments about the implications of the Court of Appeals' opinion. Swedish says that outpatient surgery is important to Washington's health care system, explains that patients prefer outpatient surgery, and cites national surveys describing an explosive growth of ambulatory surgery nationwide. Regardless of whether these claims are true, none of them have any bearing on the plain language of the Methodology. The Court of Appeals decision does not contradict, or even

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<sup>2</sup> "While the Legislature clearly wanted to control health care costs to the public, equally clear is its intention to accomplish that control by limiting competition within the health care industry. The United States Congress and our Legislature made the judgment that competition had a tendency to drive health care costs up rather than down and government therefore needed to restrain marketplace forces. The means and end here are inextricably tied."

address these issues. The Court of Appeals simply required the Department to follow the plain language of its own rules.

Swedish also makes the specious claim that tremendous unmet need exists in East King County for outpatient operating rooms, and implies that the Methodology should be manipulated to reflect that need. Swedish's unsupported assertions of a need for additional ambulatory operating rooms in the East King planning area are self-serving statements without a basis in fact. Swedish's argument that intentionally skewing the Methodology to find a need, because Swedish has independently determined that a "need" exists, turns the Methodology on its head. Swedish's claim that there is a shortage of operating rooms in East King County and that the Methodology is "conservative" based upon the use rate is unsubstantiated. Whether a need exists can only be determined by correctly applying the Methodology with data from the same sets of operating rooms when both calculating existing capacity and projecting future need.

The Department and Swedish also misstate and exaggerate the impact of the Court of Appeals decision on the public at large by arguing that the public's access to, and choice of, operating rooms will be restricted. These are false arguments because patients choose doctors, not surgical facilities. Members of the public do not simply walk into either an Ambulatory Surgical Facility or an Exempt Surgical Facility and request a surgery. Instead, patients consult with their physicians, who

recommend surgery, which is then performed in an available facility, which may be a private Exempt Surgical Facility, an Ambulatory Surgery Facility, or a hospital. Most physicians who have Exempt Surgical Facilities in their private offices also have privileges at a hospital, Ambulatory Surgical Facility, or both. Access to health care in the context of surgery means access to physicians, not to operating rooms. This argument, therefore, does not justify deliberately misconstruing the Methodology to create an oversupply of operating rooms.

Swedish and the Department also argue that if there are fewer approved Ambulatory Surgical Facilities, then more outpatient surgeries will be performed in hospitals or private physicians' offices. Again, Swedish cites to national studies that have no bearing on Washington's certificate of need regulations, policy, or the East King County planning area. If this is truly an issue with the plain language of the Methodology, then the appropriate avenue to address it is the Legislature or rulemaking, not the courts. Swedish fails to explain why the claimed policy implication of the plain language of the Methodology merits Supreme Court review, except to make the revealing statement that *Swedish's* patients will have to come to its Seattle facilities to have outpatient surgery because Swedish does not own operating rooms in East King County. Swedish's lack of presence in this market, however, does not create a crisis in health care, and the situation could easily be remedied by Swedish's physicians obtaining privileges to use the existing operating

rooms in East King County, or by Swedish building an Exempt Surgical Facility.<sup>3</sup>

Finally, the implication that there must be an oversupply of Ambulatory Surgical Centers to accommodate all surgeries currently performed in Exempt Surgical Facilities in private physicians' offices is another red herring and an attempt to exaggerate the public impact of the present case. In fact, there is no indication in the record that there is now, or will be in the future, a lack of Exempt Surgical Facilities to accommodate the surgeries that are currently performed in them. The data shows just the opposite. The number of Exempt Surgical Facilities in private physicians' offices is growing, not shrinking. No data exists to suggest that this trend will reverse or that Exempt Surgical Facilities are going to suddenly disappear. Therefore, any implication that Washington's health planning policy will be derailed by the Court of Appeals requiring the Department to follow the plain language of its own Methodology is absurd, and is not a basis for discretionary review by this Court.

d. Examples of Past "No-need" Determinations Do Not Justify Accepting Review.

Swedish again tries to distract this Court from the Court of Appeals' straightforward holding on the plain language of the Methodology by arguing that even the Department's skewed application

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<sup>3</sup> Swedish has received a certificate of need to build a hospital in Issaquah, which means that it will have available operating rooms in the East King planning area.

of the Methodology will result in a finding of no need for more operating rooms under some circumstances. This is another red herring, because the Court of Appeals was correct that the Department's "implausible interpretation" of the Methodology "will inevitably be biased toward need." *Overlake*, 200 P.3d at 248. This bias exists because, even with no population growth, the Methodology, as applied by the Department, would likely show a need for more operating rooms in planning areas with large amounts of surgeries performed in Exempt Surgical Facilities.

Nevertheless, in a few circumstances, an overwhelming surplus of existing Ambulatory Surgical Facilities or hospitals with operating rooms, or a small amount of surgeries performed in Exempt Surgical Facilities may result in a finding of no need for more operating rooms, even under the Department's skewed application of the Methodology. Swedish submits an example of such circumstances in Pierce County. *In Re MultiCare Health System Gig Harbor Ambulatory Surgery Center* (Wash. Dep't of Health Dec. 13, 2007) ("*In re MultiCare*"). In *In Re MultiCare*, the Central Pierce planning area had an oversupply of operating rooms, which was large enough to overcome the bias in the Methodology for finding a need for more operating rooms. However, an improper bias still existed in the Department's interpretation and application of the Methodology, regardless of whether a large surplus of operating rooms overcame the bias and resulted in a no-need finding. *In Re MultiCare* does not justify discretionary review of the present case.

e. The Department's Past Misapplication and Erroneous Interpretation Does Not Justify Supreme Court Review.

The Department's past erroneous interpretation of the Methodology does not mean it may continue to misconstrue the Methodology, nor does it, in itself, create an issue of substantial public interest that justifies Supreme Court review. In fact, the Department has corrected itself in the past, without requiring the Supreme Court to review the matter. In a previous certificate of need case regarding the correct application of a need methodology for open-heart surgery facilities, the Department's health law judge ruled that:

[t]he method of calculating current capacity is a question of law rather than an issue of fact, and the [Department] is not estopped from correcting its calculations consistent with the regulatory language *even though it consistently calculated current capacity using a different interpretation of the same regulatory language.*

*Overlake Hospital Medical Center and Evergreen Healthcare*, Dept. of Health Docket No. 03-06-C-2005CN, Findings of Fact, Conclusions of Law and Order of Remand, p. 2 (attached hereto as Appendix D) (emphasis added). In that case, the Department had no reservation about correcting itself, or that doing so would create an issue of "substantial public interest," despite the implications on other certificate of need cases.

This prior certificate of need decision illustrates that the Department has recognized that it must correct itself when its longstanding interpretations of its own regulatory language have been wrong.

Unfortunately, the Department did not do so here, so the Court of Appeals was required to correct the Department's wrong interpretation of the need Methodology for Ambulatory Surgical Facilities. Nevertheless, corrections to the Department's application of certificate of need methodologies do not automatically create calamity and public harm, as the exaggerated claims of Swedish and the Department suggest. The Department and Swedish are wrong to make those claims now, and their Petitions for Review should be denied.

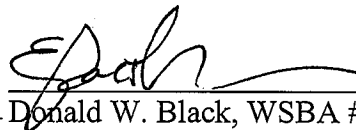
**D. CONCLUSION**

For the reasons stated above, Swedish and the Department have failed to demonstrate grounds for discretionary review. Overlake and Evergreen request that this Court deny Swedish's and the Department's Petitions for Discretionary Review.

RESPECTFULLY SUBMITTED 27<sup>th</sup> day of February, 2009.

OGDEN MURPHY WALLACE, P.L.L.C.

By:

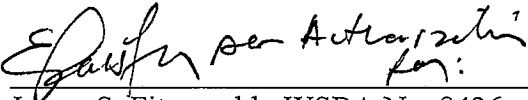


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# APPENDIX A

Westlaw

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**H**

Court of Appeals of Washington,  
 Division I.

**OVERLAKE HOSPITAL ASSOCIATION and  
 Overlake Hospital Medical Center**, a Washington  
 nonprofit corporation; and King County Public  
 Hospital District No. 2, d/b/a Evergreen Healthcare,  
 a Washington Public Hospital District, Appellants,  
 v.

DEPARTMENT OF **HEALTH** of the State of  
 Washington, Respondent.  
**No. 60554-2-I.**

Oct. 13, 2008.

Publication Ordered Jan. 20, 2009.

**Background:** Objector appealed decision of health law judge, upholding Department of Health's issuance of a certificate of need to health care provider to establish a five-bed ambulatory surgical facility. The Superior Court, King County, Julie A Spector, J., affirmed, and objector appealed.

**Holding:** The Court of Appeals, Grosse, J., held that Department decision was arbitrary and capricious.

Reversed.

West Headnotes

**[1] Administrative Law and Procedure 15A**   
**413**

15A Administrative Law and Procedure

15AIV Powers and Proceedings of Administrative Agencies, Officers and Agents

15AIV(C) Rules and Regulations

15Ak412 Construction

15Ak413 k. Administrative Construction. Most Cited Cases

Although a high level of deference is accorded to an agency's determination under the Administrative Procedure Act, such deference will not lie where an

agency's decision is based on an implausible interpretation of its regulations. West's RCWA 34.05.570.

**[2] Health 198H** **240**

198H Health

198HI Regulation in General

198HI(C) Institutions and Facilities

198Hk236 Licenses, Permits, and Certificates

198Hk240 k. Need, Public Necessity.

Most Cited Cases

Department of Health decision, issuing a certificate of need to health care provider to establish a five-bed ambulatory surgical facility, was arbitrary and capricious, since decision was based on a flawed mathematical formula to establish the number of current and projected surgeries; formula included exempt surgical procedures in calculating demand, but excluded the facilities where exempt surgical procedures are performed from the calculation of existing capacity. West's RCWA 70.38.105; WAC 246-310-270(9).

**[3] Health 198H** **104**

198H Health

198HI Regulation in General

198HI(A) In General

198Hk102 Constitutional and Statutory Provisions

198Hk104 k. Purpose. Most Cited Cases  
 In enacting the State Health Planning and Resources Development Act, the Legislature wanted to control health care costs to the public and to accomplish that control by limiting competition within the health care industry. West's RCWA 70.38.015(2).

**\*248** James Scott Fitzgerald, Gregory A. McBroom, Kirkland, WA, for King County Public Hosp.

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Donald W. Black, Jeffrey Duane Dunbar, E. Ross Farr, Ogden Murphy Wallace, Seattle, WA, for Overlake Hosp. Ass'n and Overlake Hosp. Medical Center.

Brian William Grimm, Peter Scott Ehrlichman, Seattle, WA, for Swedish Health Services.

Richard Arthur McCartan, Atty. Gen., Olympia, WA, for Dept. of Health.

GROSSE, J.

[1] ¶ 1 Although a high level of deference is accorded to an agency's determination under the Administrative Procedure Act,<sup>FN1</sup> such deference will not lie where an agency's decision is based on an implausible interpretation of its regulations. Here, the Department of Health promulgated rules for determining whether a need exists for additional ambulatory surgical facilities in Bellevue that employ a flawed mathematical formula to establish the number of current and projected \*249 surgeries. That flawed formula included exempt surgical procedures in calculating demand, but excluded the facilities where exempt surgical procedures are performed from the calculation of existing capacity. Hence, in an area where there is much private, exempt care, as Bellevue, the calculation will inevitably be biased toward need. Accordingly, we reverse the determination that Swedish Health Services could establish a five-bed ambulatory surgical facility on the eastside.

FN1. RCW 34.05.570.

## FACTS

¶ 2 The Washington Legislature enacted the State Health Planning and Resources Development Act in 1979, creating the certificate of need (CN) program to oversee health care development.<sup>FN2</sup> The CN program is an office within the Department of Health (Department) designed to effectuate the goals and principles of the Act. In order to establish

or expand health care facilities, a provider must obtain a CN.<sup>FN3</sup> For that, a health care provider must establish a need for a particular health care service or facility in that health care planning area. CN applications are evaluated based on specific criteria set forth in the statute and applicable rules.<sup>FN4</sup>

FN2. RCW 70.38.015(2).

FN3. RCW 70.38.105; *St. Joseph Hosp. v. Dep't of Health*, 125 Wash.2d 733, 735, 887 P.2d 891 (1995).

FN4. Chapter 70.38 RCW; WAC 246-310.

¶ 3 To determine whether additional inpatient and outpatient operating rooms are needed in a health planning area, the Department uses the mathematical formula set forth in WAC 246-310-270(9). This formula is a means to compare current operating room capacity in a particular health planning area against anticipated future need, if any. Essentially, the methodology requires three steps:

- Existing Capacity: calculate the capacity of existing operating rooms in the planning area;
- Future Need: project the anticipated number of surgeries in the planning area three years into the future; and
- Net Need: calculate whether the existing operating room capacity is sufficient to accommodate the projected number of future surgeries. If not, then a need exists for more ambulatory surgical facilities in the planning area.

¶ 4 Here, the Department issued a CN to Swedish Health Services (Swedish) to establish an ambulatory surgical facility with five operating rooms in Bellevue. An ambulatory surgical facility is defined as "any free-standing entity, including an ambulatory surgery center that operates primarily for the purpose of performing surgical procedures to treat patients not requiring hospitalization."<sup>FN5</sup>

FN5. WAC 246-310-010(5).

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¶ 5 Evergreen Healthcare and Overlake Hospital Medical Center (collectively, Overlake) filed an objection to the issuance of the CN to Swedish alleging that there was no need for additional ambulatory surgical facilities in the area. The health law judge rejected Overlake's appeal, upholding the methodology employed by the Department in granting Swedish the CN. Overlake appealed to the superior court which upheld the health law judge. Overlake appeals.

#### ANALYSIS

[2] ¶ 6 Certain surgical facilities are exempt under the CN scheme. Exempt facilities include those located in the offices of private physicians that are unavailable for outside use.<sup>FN6</sup> In determining current operating room capacity under the Existing Capacity step, the Department does not include exempt facilities where surgeries are currently performed. However, when computing whether additional operating rooms are needed under Future Need, the Department does include surgeries performed at exempt ambulatory surgical facilities. In short, the formula either undercounts the number of surgeries in the first step or over-counts the number of surgeries to be performed in the second step.

FN6. WAC 246-310-010(5).

\*250 ¶ 7 Overlake objects to the inclusion of surgeries at exempt facilities when the Department excludes those facilities to determine capacity. Both Existing Capacity and Future Need in the methodology use the terms "operating rooms" and "surgeries." As noted by the health law judge, the plain language of the governing WAC rule does not differentiate surgeries in exempt facilities from surgeries in nonexempt facilities. Nonetheless, the health law judge acquiesced in the Department's interpretation, permitting it to include surgeries performed at exempt facilities when calculating projected surgeries, but exclude those very same facilities when calculating the number of operating rooms needed to meet the demand for projected sur-

geries. Such an application makes no logical sense and is contrary to the basic canons of statutory interpretation. Indeed, we can envision no scenario where the Department's application of the formula will not result in a showing of need (except where there are no exempt facilities).

[3] ¶ 8 Testimony at the administrative hearing indicated that the Department's rationale for this unsound practice lay in the Legislature's policy directive to provide "accessible" health care. But, access to health care, though important, was only one reason motivating the Legislature in creating the CN program. The Legislature's primary purpose was to control costs by limiting competition.<sup>FN7</sup> The Legislature clearly enunciated its goals in its declaration of public policy:

FN7. RCW 70.38.015(1).

That strategic health planning efforts must be supported by appropriately tailored regulatory activities that can effectuate the goals and principles of the statewide health resources strategy developed pursuant to chapter 43.370 RCW. The implementation of the strategy can promote, maintain, and assure the health of all citizens in the state, provide accessible health services, health manpower, health facilities, and other resources *while controlling increases in costs*, and recognize prevention as a high priority in health programs.<sup>[FN8]</sup>

FN8. RCW 70.38.015(1) (emphasis added).

As the Supreme Court in *Saint Joseph Hospital v. Department of Health* noted:

While the Legislature clearly wanted to control health care costs to the public, equally clear is its intention to accomplish that control by limiting competition within the health care industry. The United States Congress and our Legislature made the judgment that competition had a tendency to drive health care costs up rather than down and

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government therefore needed to restrain market-place forces. The means and end here are inextricably tied.<sup>[FN9]</sup>

FN9. 125 Wash.2d 733, 741, 887 P.2d 891 (1995).

The formula as interpreted and applied here by the Department is not particularly helpful in achieving any of these goals as it results in a formula that is fundamentally unsound. Sound reasoning requires the concomitant inclusion or exclusion of exempt facilities. To do otherwise defies logic and the plain meaning of the language used throughout the pertinent WAC.

¶ 9 On remand, the Department may very well come to the same conclusion it reached. Indeed, there is nothing that would prevent the Department from discounting private surgical procedures and facilities entirely should it so choose. But here, the Department's decision to issue Swedish the CN was arbitrary and capricious because it was based on an erroneous interpretation of the governing statutes and a misapplication of its own regulations. The Department's calculation necessarily resulted in an over-calculation of future need for additional outpatient operating rooms in the East King County Planning Area. Because we find that the Department misapplied its own rule (WAC 246-310-270(9)),<sup>FN10</sup> we reverse.

FN10. The WAC provides in pertinent part:

(9) Operating room need in a planning area shall be determined using the following method:

(a) Existing capacity.

(i) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is ninety-four thousand two hundred fifty minutes. This is derived from scheduling

forty-four hours per week, fifty-one weeks per year (allowing for five week-day holidays), a fifteen percent loss for preparation and clean-up time, and fifteen percent time loss to allow schedule flexibility. The resulting seventy percent productive time is comparable to the previously operating hospital commission's last definition of "billing minutes" which is the time lapse from administration of anesthesia until surgery is completed.

(ii) Assume the annual capacity of one operating room dedicated to ambulatory surgery is sixty-eight thousand eight hundred fifty minutes. The derivation is the same as (a)(i) of this subsection except for twenty-five percent loss for prep/clean-up time and scheduling is for a thirty-seven and one-half hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see (a)(vii) of this subsection). Where survey data are unavailable, assume fifty minutes per outpatient surgery, resulting in a capacity for one thousand three hundred seventy-seven outpatient surgeries per room per year.

(iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.

(iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating the need in an area. Exclude cystoscopic and other special purpose rooms (e.g., open heart surgery) and delivery rooms.

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(b) Future need.

(i) Project number of inpatient and outpatient surgeries performed within the hospital planning area for the third year of operation. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.

(ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculation of (b)(iv) of this subsection.

(iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes."

(iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

(c) Net need.

(i) If (b)(iv) of this subsection is less than (a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

(ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating

rooms. Divide the outpatient component of (b)(iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

WE CONCUR: ELLINGTON and BECKER, JJ.  
Wash.App. Div. 1,2008.  
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## APPENDIX B



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**C**

**WASHINGTON ADMINISTRATIVE CODE  
TITLE 246. HEALTH, DEPARTMENT OF  
CHAPTER 246-310. CERTIFICATE OF NEED**

Current with amendments adopted through December 3, 2008.

246-310-270. Ambulatory surgery.

(1) To receive approval, an ambulatory surgical facility must meet the following standards in addition to applicable review criteria in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240.

(2) The area to be used to plan for operating rooms and ambulatory surgical facilities is the secondary health services planning area.

(3) Secondary health services planning areas are: San Juan, Whatcom, East Skagit, Whidbey-Fidalgo, Western North Olympic, East Clallam, East Jefferson, North Snohomish, Central Snohomish, East Snohomish, Southwest Snohomish, Kitsap, North King, East King, Central King, Southwest King, Southeast King, Central Pierce, West Pierce, East Pierce, Mason, West Grays Harbor, Southeast Grays Harbor, Thurston, North Pacific, South Pacific, West Lewis, East Lewis, Cowlitz-Wahkiakum-Skamania, Clark, West Klickitat, East Klickitat, Okanogan, Chelan-Douglas, Grant, Kittitas, Yakima, Benton-Franklin, Ferry, North Stevens, North Pend Oreille, South Stevens, South Pend Oreille, Southwest Lincoln, Central Lincoln, Spokane, Southwest Adams, Central Adams, Central Whitman, East Whitman, Walla Walla, Columbia, Garfield, and Asotin.

(4) Outpatient operating rooms should ordinarily not be approved in planning areas where the total number of operating rooms available for both inpatient and outpatient surgery exceeds the area need.

(5) When a need exists in planning areas for additional outpatient operating room capacity, preference shall be given to dedicated outpatient operating rooms.

(6) An ambulatory surgical facility shall have a minimum of two operating rooms.

(7) Ambulatory surgical facilities shall document and provide assurances of implementation of policies to provide access to individuals unable to pay consistent with charity care levels provided by hospitals affected by the proposed ambulatory surgical facility. The amount of an ambulatory surgical facility's annual revenue utilized to finance charity care shall be at least equal to or greater than the average percentage of total patient revenue, other than medicare or medicaid, that affected hospitals in the planning area utilized to provide charity care in the last available reporting year.

(8) The need for operating rooms will be determined using the method identified in subsection (9) of this section.

(9) Operating room need in a planning area shall be determined using the following method:

(a) Existing capacity.

(i) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpa-

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tient surgery is ninety-four thousand two hundred fifty minutes. This is derived from scheduling forty-four hours per week, fifty-one weeks per year (allowing for five weekday holidays), a fifteen percent loss for preparation and clean-up time, and fifteen percent time loss to allow schedule flexibility. The resulting seventy percent productive time is comparable to the previously operating hospital commission's last definition of 'billing minutes' which is the time lapse from administration of anesthesia until surgery is completed.

(ii) Assume the annual capacity of one operating room dedicated to ambulatory surgery is sixty-eight thousand eight hundred fifty minutes. The derivation is the same as (a)(i) of this subsection except for twenty-five percent loss for prep/clean-up time and scheduling is for a thirty-seven and one-half hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see (a)(vii) of this subsection). Where survey data are unavailable, assume fifty minutes per outpatient surgery, resulting in a capacity for one thousand three hundred seventy-seven outpatient surgeries per room per year.

(iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.

(iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating the need in an area. Exclude cystoscopic and other special purpose rooms (e.g., open heart surgery) and delivery rooms.

(b) Future need.

(i) Project number of inpatient and outpatient surgeries performed within the hospital planning area for the third year of operation. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.

(ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculation of (b)(iv) of this subsection.

(iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to 'billing minutes.'

(iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

(c) Net need.

(i) If (b)(iv) of this subsection is Less than a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

(ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient

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component of (b)(iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

Statutory Authority: RCW 70.38.135 and 70.38.919. 92-02-018 (Order 224), S 246-310-270, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as S 246-310-270, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 70.38.919. 90-16-058 (Order 073), S 248-19-700, filed 7/27/90, effective 8/27/90.

<General Materials (GM) - References, Annotations, or Tables>

WAC 246-310-270, **WA ADC 246-310-270**

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## APPENDIX C

OGDEN MURPHY WALLACE, PLLC

Docket No. 03-06-C-2001CN

Superior Court appealing the order. The Superior Court remanded the matter for further action.

### **ISSUES**

1. Whether Swedish correctly included the number of surgeries performed at exempt ambulatory surgery center operating rooms in its WAC 246-310-270 calculation of the surgical procedure, use rate, and correctly excluded the number of exempt ambulatory surgery center operating rooms in its calculation of the existing operating room capacity determination?
2. Whether the Program's decision to grant the Swedish certificate of need application should be granted?

### **SUMMARY OF THE EVIDENCE**

Randall Huyck, Robin Edward MacStravic, and Jody Carona testified at the hearing. The following thirteen exhibits were admitted at the hearing:

- Exhibit 1: The Swedish Certificate of Need Application Record.
- Exhibit 2: Health Service Area Map showing Southeast (yellow) and East (blue) King County Service Areas.
- Exhibit A: Program analysis in the Northwest Nasal Sinus Center application (Certificate of Need No. 1250).
- Exhibit B: Resume of Robin Edward MacStravic, Ph.D.
- Exhibit C: Deposition of Program Analyst Randy Huyck, taken August 27, 2003 (pages 58 through 95).
- Exhibit D: Facsimile dated August 20, 2003, with Program work sheets used in the original analysis date of August 15, 2003.

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Exhibit E: Four ambulatory surgery center need methodology worksheets prepared by Jody Carona, Health Service Planning & Development, based on the Program's worksheets and data in the record, demonstrating the numerical need:

- E-1: In the Swedish defined planning area if all exempt ambulatory surgery center operating rooms are included in the available supply;
- E-2: In the Swedish planning area if all surgeries performed in all exempt ambulatory surgery center operating rooms are excluded from the use rate;
- E-3: In the East King County planning area if all exempt ambulatory surgery center operating rooms are included in the available supply; and
- E-4: In the East King County planning area if all surgeries performed in all exempt ambulatory surgery center operating rooms are excluded from the use rate.

Exhibit F: Oversized Map of Proposed Service Area for Swedish ambulatory surgery center (Exhibit 7 from the Huyck deposition).

Exhibit G: Swedish Defined Service Area (actual Swedish defined service area facilities per Department of Health directory of certified ambulatory surgery centers and Swedish application).

Exhibit H: Summary of East King Surgery 2001 Utilization Data and Use Rate Calculations corrected Calculation of Need – Northwest Nasal Surgery Center.

Exhibit I: 2006 East King Secondary Health Service Area – Excluding Exempt Facilities.

Exhibit J: Swedish Bellevue Ambulatory Surgery Center Need Methodology:

- J-1: Methodology using 102/1000 use rate.
- J-2: Methodology using 82/1000 use rate.
- J-3: Methodology using 57/1000 use rate.

J-4: Methodology using 76/1000 use rate.

Exhibit K: November 27, 2002 letter to Lori Aoyama, Health Facilities Planning & Development, from Randy Huyck (with attached copies of the Program's application of the ambulatory surgery center numeric need methodology contained in WAC 246-310-270).

K-1: Program methodology.

K-2: Methodology using Evergreen/Overlake number of surgeries (prepared November 27, 2002).

K-3: Methodology using Northwest Nasal Sinus Center projected surgeries (prepared November 27, 2002).

K-4: Methodology as prepared by applicant Northwest Nasal Sinus Center (prepared November 27, 2002).

K-5: East King Ambulatory Surgery Center Survey CN Facilities (prepared November 27, 2002).

K-6: East King Ambulatory Surgery Center Survey All Responding (prepared November 27, 2002).

Based on the evidence and exhibits in this matter, the Presiding Officer enters the following:

## **I. FINDINGS OF FACT**

### **A. Background**

1.1 The Certificate of Need Program (the Program) granted Swedish Health Services (Swedish) Certificate of Need No. 1264 to establish an ambulatory surgical facility in Bellevue, Washington. Overlake Hospital Medical Center and Evergreen Healthcare (the Petitioners) appealed the Program's decision. Swedish was permitted to intervene in the appeal.

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1.2 On July 8, 2005, the Presiding Officer issued an Amended Findings of Fact, Conclusions of Law and Final Order (the Final Order). The Final Order reversed the Program's decision that granted the certificate of need to Swedish.

1.3 On August 9, 2005, Swedish filed a Petition for Judicial Review in King County Superior Court pursuant to RCW 34.05.530. On April 19, 2006, King County Superior Court Judge Douglas North issued an Order Reversing the Presiding Officer's Amended Findings of Fact, Conclusions of Law and Final Order, and Remanding to the Presiding Officer for Further Proceedings (the Remand Order). Judge North ruled, in relevant part:

Accordingly, the Presiding Officer's Final Order is affirmed in part and reversed in part. The case is remanded to the Presiding Officer, based on the evidence presented by the parties to the Department of Health during the application process and the adjudicative proceeding, to (i) determine whether Swedish's proposed ASC satisfies the certificate of need criteria, using the East King County planning area; and (ii) address any other issues raised by the parties in the prior adjudicative proceeding and not previously addressed in the Final Order or this order.

The Remand Order at 2.

1.4 Surgery can be performed on an inpatient or outpatient basis.<sup>1</sup> Inpatient surgery is when a person's surgery requires board and room in a health care facility (i.e., a hospital) on a continuous twenty-four-hour-a-day basis.<sup>2</sup> Therefore, outpatient surgery is when a person's surgery requires less than twenty-four hour care. When a

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<sup>1</sup> "Surgery" means that "branch of medicine dealing with the manual and operative procedures for correction of deformities and defects, repair of injuries, and diagnosis and cure of certain diseases." Taber's Cyclopedic Medical Dictionary (14<sup>th</sup> Edition, 1981), at 1395.

<sup>2</sup> See WAC 246-310-010.

need exists for additional outpatient operating room capacity, preference is given to dedicated outpatient operating rooms.<sup>3</sup>

1.5 When a person receives surgery on an outpatient basis, that surgery can be performed in an ambulatory surgical facility. An "ambulatory surgical facility" is a free standing entity that operates primarily for the purpose of performing outpatient surgical procedures, that is surgery for patients who do not require hospitalization.<sup>4</sup> To qualify as an ambulatory surgical facility, the facility must have a minimum of two operating rooms.<sup>5</sup> The facility can be located in a private physician or dentist office. When the use of the facility is not restricted to a specific individual or group practice, the facility can qualify as an ambulatory surgical facility. When a facility's use is restricted to a specific individual or group practice, by definition, it is not an ambulatory surgical facility.<sup>6</sup> These exempt facilities can be referred to as ambulatory surgical centers.<sup>7</sup>

1.6 Characterizing a facility as an ambulatory surgical facility or an ambulatory surgical center is important under the law. An ambulatory surgical facility must obtain a certificate of need to operate in the state of Washington.<sup>8</sup> An ambulatory surgical center is exempt from the certificate of need requirement.

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<sup>3</sup> WAC 246-310-270(5).

<sup>4</sup> WAC 246-310-010.

<sup>5</sup> WAC 246-310-270(6) and WAC 246-310-010. To "operate" is "to perform an incision or to make a suture on the body or any of its organs or parts to restore health." Taber's Cyclopedic Medical Dictionary (Edition 14, 1981), at 990.

<sup>6</sup> See WAC 246-310-010.

<sup>7</sup> The term ambulatory surgical center is not defined in chapter 246-310 WAC. The term is being used to help to differentiate between exempt and non-exempt facilities.

<sup>8</sup> WAC 246-310-270(1).

1.7 The decision whether to grant or deny an ambulatory surgical facility certificate of need application is determined by using a mathematical formula or methodology to determine whether there is a "need" for an additional facility (that is, a requirement for additional operating room capacity).<sup>9</sup> To determine whether need for an additional facility exists requires the identification of a geographic region known as a secondary health services planning area (the health planning area).<sup>10</sup> If the applicant can show there is a net need for dedicated outpatient operating rooms in the relevant health planning area in the future (three years after the applicant anticipates starting the operation of the facility) the application is granted. If no need exists, the application is denied.

1.8 Need exists if more operating room capacity is required in the project year. Capacity speaks to the number of surgeries that can be performed in an operating room. The surgery information is obtained from information derived from surveys provided by facilities in the health planning area or by use of a default figure provided in the regulation. Facilities in a health planning area are not required to complete the surveys regarding surgical capacity at their respective facilities. Thus, the capacity calculations in any given application are affected by the number of facilities that reply to the submitted surveys.<sup>11</sup>

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<sup>9</sup> WAC 246-310-270(9).

<sup>10</sup> WAC 246-310-270(3).

<sup>11</sup> The Program analyst acknowledged at hearing that an issue exists with any use rate calculations, as the figure is calculated without receiving complete surgical statistics.

1.9 Deciding whether future operating room capacity is necessary requires the calculation of a figure known as a "use rate." The use rate means a projection of the number of inpatient and outpatient surgeries within the applicant's health planning area for the applicant's target year (the third year of operation).<sup>12</sup> The projection is based on the current number of surgeries adjusted for the forecasted growth in the population served, and may be adjusted for trends in surgeries per capita (that is, surgeries according to the number of individuals). The use rate is represented by a percentage of surgeries required per each one thousand population (for example, 100 surgeries per each 1000 individuals, or 100/1000).

1.10 When calculating the use rate for a health planning area, it is necessary to include the surgical volume or number of surgeries that have been performed both in ambulatory surgical centers (that is, surgical centers that are exempt from the requirement of obtaining a certificate of need) and ambulatory surgical facilities (non-exempt facilities which are required to obtain a certificate of need). When calculating the number of existing facilities in a health service area, it is necessary to exclude from that count the number of operating rooms from ambulatory surgical centers (exempt facilities). The calculation performed under this regulation requires a comparison of separate concepts: (1) The total volume or number of inpatient and outpatient surgeries which have been performed in the planning area; and (2) the amount of capacity or facilities needed to accommodate the number of anticipated future surgeries (based on the anticipated increase in the population) in the health planning area.

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<sup>12</sup> See WAC 246-310-270(9)(b)(i).

1.11 The number of anticipated future surgeries can be calculated by applying the use rate to the anticipated future population. Determining whether an individual will obtain that future surgery, in an ambulatory surgical center (an exempt facility) or an ambulatory surgical facility (a non-exempt facility) cannot be reduced to a mathematical formula. The first concept (anticipated future surgeries) is a numerical value. The second concept (the location of the future surgery) cannot be determined with mathematical certainty. For example, a patient who may qualify for surgery at an exempt ambulatory surgical center in the present may not qualify for surgery in the future at the same exempt facility. Another example is a surgeon who holds surgical privileges at an exempt ambulatory surgical center in the present, may not hold surgical privileges at the same facility in future. Finally, the exempt ambulatory surgical center may no longer exist.

B. Need.

1.12 What does this mean for calculating the need methodology? It means capturing all current surgical capacity statistics from ambulatory surgical facilities (non-exempt facilities) and ambulatory surgical centers (exempt facilities) in calculating existing capacity, but calculating future need considering only ambulatory surgical facilities to ensure that the patients have access to surgical facilities in the future.

1.13 Swedish submitted its application to establish the free-standing ambulatory surgical facility in November 2002. Under its application, the third year of operation would be 2006. Swedish provided need calculation information as a part of its application. The Swedish information shows that with a use rate of 102/1000 (based on

National Center for Health Statistics data) and a population of 533,055 in 2004 (based on the Northwest Nasal Sinus Center application) there existed a net need for 5.9 outpatient operating rooms. PR 316–317. With a use rate of 82/100 (obtained from the Northwest Nasal Sinus Center application) and using the same 2004 population figure, there existed a net need for 1.0 outpatient operating rooms. PR 319.

1.14 The Swedish need calculations under WAC 246-310-270(9) included all surgery date, whether those surgeries were performed in an ambulatory surgery center (an exempt facility) or an ambulatory surgical facility (a non-exempt facility). When calculating whether need existed, Swedish performed those calculations using only ambulatory surgical facility operating rooms to show the existence of a surplus or shortage of dedicated outpatient operating rooms.

1.15 The Program submitted need figures at hearing based on information contained in the Swedish application records. With a use rate of 82/1000 and a 2006 population figure of 546,288, there existed a net need for 5.39 dedicated outpatient operating rooms. Exhibit J-2.

1.16 The Program need calculations under WAC 246-310-270(9) included all surgery data, whether those surgeries were performed in an ambulatory surgical center (an exempt facility) or an ambulatory surgical facility (a non-exempt facility). When calculating whether need existed, the Program performed those calculations using only ambulatory surgical facility operating rooms to show the existence of a surplus or shortage of dedicated outpatient rooms.

1.17 Information in both the Swedish application and the Program's certificate of need analysis show need exists. However, Swedish used 2004 population information as opposed to 2006 population figures (the third year of operation) as required under WAC 246-310-270(9)((b)(i). The Northwest Nasal Sinus Center use rate (82/1000) was based on state population information as opposed to national population figures from the National Center for Health Statistics (102/1000).

1.18 In calculating whether operating room need exists, the appropriate use rate is be 82/1000, as this figure is derived from state population information and the appropriate health planning area. The appropriate population information is the 2006 population information from the East King County health planning area. That population figure is 546,288. See Exhibit J-2. The calculations show a net need for an additional 5.39 dedicated outpatient operating rooms. Therefore, need exists.

1.19 All surgery data (the total number of surgeries performed) was included in the calculations in Finding of Fact 1.18 above, whether those surgeries were performed in an ambulatory surgical center (an exempt facility) or an ambulatory surgical facility (a non-exempt facility). When calculating whether need existed in Finding of Fact 1.18, calculations were performed using only ambulatory surgical facility outpatient operating rooms to show a shortage of dedicated outpatient operating rooms in the East King County health planning area.

C. Remaining Certificate of Need Criteria.

1.20 Swedish provided financial information to show that the immediate and long range capital and operating costs for its proposed ambulatory surgical facility

project could be met. The Program considered whether the Swedish project was financially feasible by using a financial ratio analysis to assess the financial impact of the project on the overall facility operation. PR 563-564. The Program also compared costs of the project and determined the Swedish project would not result in an unreasonable impact on the costs and charges for health services within the service area. PR 565. Swedish provided sufficient information to show that it could finance the project from available cash reserves. PR 566.

1.21 Swedish provided information to show that it could meet the structure and process (quality) of care for the project. Swedish provided sufficient information in its application to show that it could meet staffing requirements, establish sufficient ancillary and support services and would conform to any applicable legal requirements. PR 566-568.

1.22 Swedish provided information in its application to show that it could meet the cost containment requirements of the project. Swedish provided information to show it had considered whether there were any superior alternatives to its proposal to establish an ambulatory surgical facility, and that the project would not have an impact on the costs and charges to the public. PR 566-568.

## **II. CONCLUSIONS OF LAW**

2.1 The certificate of need program is regulated pursuant to chapter 70.38 RCW and chapter 246-310 WAC. The development of health services and resources should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation.

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RCW 70.38.015(2).

2.2 In all license application cases, the burden shall be on the applicant to establish that the application meets all applicable criteria. WAC 246-10-606.<sup>13</sup> The Program then decides whether to grant or deny a certificate of need application. The Program's written decision must contain sufficient information to support the Program's decision granting or denying the application. See WAC 246-310-200(2)(a); *see also In re Auburn Regional Medical Center*, Docket No. 01-05-C-1052CN (February 20, 2003). Evidence is admissible in certificate of need hearings if it is the kind of evidence on which reasonably prudent persons are accustomed to rely on in the conduct of their affairs. RCW 34.04.452; WAC 246-10-606.

2.3 In general a certificate of need hearing does not supplant the certificate of need application review process. Rather, the hearing assures that the procedural and substantive rights of the parties have been observed and factual record supports the Program's decision and analysis. *In re Ear, Nose, Throat*, Docket No. 00-09-C-1037CN (April 17, 2001) (Prehearing Order No. 6). While the hearing does not supplant the certificate of need review process under normal circumstances, the King County Superior Court remanded the proceeding to the Presiding Officer in this case to determine whether the application should be granted using information contained in the application record regarding the East King County planning area. The remand order also required the Presiding Officer to address any other issues raised by the parties in the prior

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<sup>13</sup> Certificate of need proceedings are governed by the Administrative Procedure Act (chapter 34.05 RCW), chapter 246-310 WAC and chapter 246-08 WAC. WAC 246-310-610: The relevant sections in chapter 246-08 WAC were replaced in 1993 by chapter 246-10 WAC. WAC 246-10-101

adjudicative proceeding and not previously addressed in the Final Order or this order.

See the Remand Order, page 2.

A. First Remand Issue: Need.

2.4 There is sufficient information in the Swedish application file to answer the first issue identified in the Remand Order, specifically to determine whether the ambulatory surgical facility proposed by Swedish satisfied the certificate of need criteria using the East King County planning area. See Findings of Fact 1.13 through 1.18. Regarding the 2006 project year, there is need for an additional 5.39 operating rooms in the East King County planning area. See Finding of Fact 1.18.

B. Second Remand Issue: Issue Not Previously Addressed in Earlier Final Order.

2.5 Answering the first issue (determining if need exists in the East King County planning area) requires answering another issue that was not addressed in the Amended Final Order. That issue is whether, when calculating operating room need under WAC 246-310-270(9), the applicant can include the number of surgeries performed at an exempt ambulatory surgical center when determining the surgical procedure use rate, but exclude the number of operating rooms in an exempt ambulatory surgical center from the count in existing capacity. The Certificate of Need Program has historically used this approach in reviewing ambulatory surgical facility applications.

2.6 The rule which is applied is WAC 246-310-270. That rule provides, in pertinent part:

(9) Operating room need in a planning area shall be determined using the following method:

(a) Existing capacity.

(iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.

(iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating the need in the area. Exclude cystoscopic and other special purpose rooms (e.g. open heart surgery) and delivery rooms.

(b) Future need.

(i) Project number of inpatient and outpatient surgeries performed within the third year of operation. This shall be based on current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.

(ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculations of (b)(iv) of this subsection.

(iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes".

(iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

(c) Net Need.

(i) If (b)(iv) of this subsection is less than (a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

(ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of (b)(iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

WAC 246-310-270(9) (emphasis added).

2.7 When capturing outpatient surgery data (the number of surgeries) for use in calculating future need, all outpatient surgery data should be included in the final data figure. All outpatient surgery data means data from both exempt and non-exempt facilities. The plain language of WAC 246-310-270(9)(a)(iii) requires that operating room need shall be determined using the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area. The plain language of the rule does not differentiate between exempt (ambulatory surgical centers) and non-exempt (ambulatory surgical facilities). Rules of statutory construction apply to administrative rules and regulations, particularly where they are adopted pursuant to express legislative authority. See *State v. Burke*, 92 Wn.2d 474, 478 (1979). Where the meaning of a provision is plain on its face, the court must give effect to that plain meaning as an expression of legislative intent. *City of Olympia v. Drebeck*, 156 Wn.2d 289, 295 (2006) (citing *Department of Ecology v. Campbell & Gwinn LLC*, 146 Wn.2d 1, 9-10 (2002)).

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2.8 The next question is whether the WAC 246-310-270(9)(b) and (c) language is equally clear regarding the calculation of operating room need? In other words is the operating room need calculation restricted to only the number of non-exempt (ambulatory surgical facility) operating rooms, or all operating rooms consistent with the reading of WAC 246-310-270(9)(a). A reading of the regulatory language in WAC 246-310-270(9)(b) speaks to projecting the number of inpatient and outpatient surgeries performed in the planning area. This language appears to be all inclusive, similar to a reading of the capacity language set forth in WAC 246-310-270(9)(a).

2.9 However, the language of WAC 246-310-270(9)(b) and (c) cannot be read in isolation. A provision's plain meaning may be ascertained by an examination of the statute in which the provision at issue is found, as well as related statutes or other provisions of the same act in which the provision is found. *City of Olympia v. Drebeck*, 156 Wn.2d at 295 (internal citations omitted). The legislative declaration of public policy states that health planning should promote, maintain, and assure that all citizens have accessible health services. See RCW 70.38.015(1). If the more inclusive approach were followed, the calculation of available operating rooms would include ambulatory surgery center (exempt) operating rooms that would not be available to many of the individuals within the health planning area. See Findings of Fact 1.11 and 1.12. For this reason, while all surgeries from whatever source should be included in the existing capacity calculations under WAC 246-310-270(9)(a), that inclusive approach should not

be used in determining the future need/net need calculation under WAC 246-310-270(9)

(b) and (c).

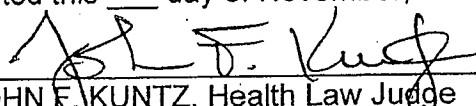
### III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law of the Amended Final Order, and the above Findings of Fact and Conclusions of Law following the King County Superior Court remand order, it is ORDERED:

3.1 There is a net need for 5.39 additional dedicated outpatient operating rooms in the East King County planning area in the 2006 project year.

3.2 Certificate of Need No. 1264 for Swedish Health Services to establish an ambulatory surgical facility in Bellevue, Washington, is GRANTED.

Dated this 9<sup>th</sup> day of November, 2006.

  
JOHN F. KUNTZ, Health Law Judge  
Presiding Officer

### NOTICE TO PARTIES

Either party may file a petition for reconsideration. RCW 34.05.461(3); . RCW 34.05.470. The petition for reconsideration must be filed within 10 days of service of this Order with:

Adjudicative Service Unit  
P.O. Box 47879  
Olympia, WA 98504-7879

And a copy must be sent to:

Certificate of Need Program  
P.O. Box 47852  
Olympia, WA 98504-7852

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The petition must state the specific grounds upon which reconsideration is requested and the relief requested. The petition for reconsideration is considered denied 20 days after the petition is filed if the Adjudicative Service Unit has not responded to the petition or served written notice of the date by which action will be taken on the petition.

A petition for judicial review must be filed and served within 30 days after service of this Order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, however, the 30-day period will begin to run upon the resolution of that petition.

This order remains in effect even if a petition for reconsideration or petition for judicial reviewed is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This Order was "served" upon you on the day it was deposited in the United States mail. RCW 34.05.010(19).

## APPENDIX D

STATE OF WASHINGTON  
DEPARTMENT OF HEALTH  
ADJUDICATIVE SERVICE UNIT

RECEIVED  
AUG 23 2004  
Ogden Murphy Wallace PLLC

In the Matter of:

Docket No. 03-06-C-2005CN

OVERLAKE HOSPITAL MEDICAL  
CENTER, a Washington non-profit  
Corporation; and KING COUNTY  
PUBLIC HOSPITAL DISTRICT NO. 2,  
Dba EVERGREEN HEALTHCARE,  
A Washington public hospital district,

FINDINGS OF FACT,  
CONCLUSIONS OF LAW  
AND ORDER OF REMAND

Petitioners.

APPEARANCES:

Petitioner, Overlake Hospital Medical Center, by  
Ogden Murphy Wallace PLLC, per  
Donald W. Black, Attorney at Law

Petitioner, King County Public Hospital District No. 2,  
dba Evergreen Healthcare, by  
Livengood Fitzgerald & Alskog PLLC, per  
James S. Fitzgerald, Attorney at Law

Intervenor, Swedish Health Services,  
dba Swedish Medical Center, by  
Bennett Bigelow & Leedom P.S., per  
Stephen I Pentz, Attorney at Law

Department of Health Certificate of Need Program, by  
The Office of the Attorney General, per  
Richard A. McCartan, Assistant Attorney General

PRESIDING OFFICER: John F. Kuntz, Health Law Judge

The Presiding Officer, through authority delegated to him by the Secretary of  
Health, conducted a hearing on January 8 and January 9, 2004, in Tumwater,  
Washington. On May 27, 2003, the Certificate of Need Program denied the joint open-

FINDINGS OF FACT,  
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AND ORDER OF REMAND

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heart surgery (OHS) and percutaneous transluminal coronary angioplasty (PTCA)

application filed by Overlake Hospital Medical Center and Evergreen Healthcare.

Remanded.

## ISSUES

Did the Program correctly calculate "current capacity" in step one of the open-heart surgery need methodology when analyzing the Petitioners' open-heart surgery facility application?

If the Program did not correctly calculate current capacity, must the Program engage in the rule making process under the Administrative Procedure Act (chapter 34.05 RCW) before correcting its current capacity computation?

When it consistently followed a different interpretation of the current capacity definition when approving previous applications, is the Program estopped from computing the planning area's current capacity using the "correct" definition?

Would granting the Petitioners' application cause the reduction of an existing program below the 250 OHS minimum volume standard under WAC 246-310-261(3)(c), when the existing program's OHS surgery numbers were already below the minimum volume standard at the time of the application?

## SUMMARY OF DECISION

The Program did not correctly apply the need forecast methodology set forth in chapter 70.38 RCW and WAC 246-310-261 when analyzing the Petitioners' open-heart surgery application. The Program failed to calculate current capacity in a manner consistent with the regulatory definition set forth in WAC 246-310-261(5)(b) when calculating step one of the forecast need methodology.

The method of calculating current capacity is a question of law rather than an issue of fact, and the Program is not estopped from correcting its calculations consistent with the regulatory language even though it consistently calculated current capacity using a different interpretation of the same regulatory language. Given the regulation is unambiguous on its face, the Program is not required to engage in the APA rule-making process before interpreting the current capacity regulatory language to the Petitioners' joint application.

The language of WAC 246-310-261(3)(c) does not directly address the issue of the reduction of an existing OHS program that has not reached the 250 OHS minimum standard. Because it is ambiguous, statutory construction rules apply in interpreting the regulation. When read in context with other chapter 246-310 WAC provisions, and given that tertiary health services providers are required to reach sufficient patient volumes to optimize provider effectiveness and quality of services, any reduction of an existing providers volume, even for an existing provider that has not reached the minimum standard, appears contrary to the legislative intent of chapter 70.30 RCW and WAC 246-310-261(3)(c).

### **PROCEDURAL HISTORY**

On August 30, 2002, Overlake Hospital Medical Center and Evergreen Hospital Medical Center (the Petitioners) filed a joint application for a certificate of need to establish an open-heart surgery (OHS) and nonemergent percutaneous transluminal coronary angioplasty (PTCA) service program at the Evergreen Healthcare facility. The Program denied the joint application on May 27, 2003, and the Petitioners appealed the Program's denial decision on June 24, 2003. A three day hearing was scheduled for January 7 – 9, 2004. Swedish Health Services requested, and was granted, intervention on a limited basis under RCW 70.38.115(10) on August 29, 2003. Prehearing Order No. 1.

On November 12, 2003, the Intervenor moved to consolidate the Good Samaritan and Overlake/Evergreen proceeding, arguing the two proceedings involved similar factual and legal issues. The Program filed a memorandum in support of the Intervenor's motion on November 17, 2003. The consolidation motion was denied on the grounds that Good Samaritan and the Petitioners were not considered competing parties and the Intervenor (Swedish) had not intervened in the Good Samaritan matter. Prehearing Order No. 5.

On November 14, 2003, the Program moved to remand the decision on the Petitioners application to correct errors the Program contended it made in applying the OHS/PTCA methodology. The Program argued OHS figures from Harrison Hospital (a facility located in the same health service area that recently received an OHS/PTCA certificate of need) were not included in the WAC 246-310-261 calculations and figures relating to DRG 514 and 515 needed to be included under WAC 246-310-261(5)(e).

The Petitioners opposed the remand motion, arguing:

- (1) Neither the APA nor agency regulations permitted remand of an agency decision during an adjudicative proceeding to review agency errors;
- (2) A remand action would effectively continue the hearing date without showing any good cause existed to do so; and
- (3) The Petitioners disagree that any methodology errors exist in the present case.

The remand motion was denied on December 15, 2003. Prehearing Order No. 6.

On December 15, 2003, the Program moved for summary judgment, arguing:

- (1) The three changes made to the methodology were "correct";
- (2) The properly performed methodology mandates a denial of the application; and
- (3) The Program was not equitably estopped from correcting the methodology under Washington case law.

The Petitioners opposed the motion as untimely, as it was filed less than 28 days before the scheduled hearing date. See CR 56. Because it was unclear that the Program's most recent interpretation of WAC 246-310-261 was "correct", and given the

timing of the filing of the motion, the Presiding Officer denied the summary judgment motion on December 19, 2003. Prehearing Order No. 8.

The certificate of need application file was admitted as an exhibit at the prehearing conference. Prehearing Order No. 8. The hearing was conducted on January 8 and January 9, 2004. The parties agreed to incorporate the Good Samaritan hearing exhibits in the present hearing. OE RP at 9 – 10<sup>1</sup>. The Good Samaritan exhibits were:

- Exhibit 1: Certificate of Need application (Good Samaritan).
- Exhibit 2: OHS Current Capacity (1999 – 2001), prepared December 3, 2003 (new methodology differing from the one attached to the Program's denial decision).
- Exhibit 3: DRG 514 and 515 procedures by hospital/state for 2001.
- Exhibit 4: OHS Current Capacity (1999- 2001) prepared December 3, 2003 (variation of Exhibit 2, taking into account DRG codes 514 and 515).
- Exhibit 5: Calculation of Good Samaritan Hospital's proposed OHS Program on Tacoma General Hospital.
- Exhibit 6: Curriculum Vitae for Nayak L. Pollisar, Ph.D., dated September 22, 2003.
- Exhibit 7: Regression analysis charts (using data from 1997 to 2001).
- Exhibit 8: Charts regarding internal referral of cases; cumulative percentage of cases vs. average length of stay; and cumulative proportion of cases vs. DRG WT 2 for St. Joseph Medical Center and Tacoma General Hospital (re: acuity).

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<sup>1</sup> The parties agreed to incorporate portions of the Good Samaritan hearing transcript in the present hearing. For ease of reference the Good Samaritan report of proceedings is referred to as GS RP, and the Overlake/Evergreen report of proceedings as OE RP. Reference to the application record is identified by the abbreviation AR and the relevant page number. References to the hearing transcript will be identified by the abbreviation RP (report of proceeding), and referenced by the specific RP and relevant page number.

- Exhibit 9: Comparison of Tacoma General Hospital and St. Joseph Medical Center on case acuity (DRG WT 2).
- Exhibit 10: Second Declaration of Charles Frank (with attachments). Admitted on a limited basis.
- Exhibit 11: Department of Health analysis granting OHS/PTCA certificate of need to Harrison Memorial Hospital, dated November 2, 2001.

At the Overlake/Evergreen hearing the following additional exhibits were admitted (except where noted):

- Exhibit 13: Rick Ordos declaration in lieu of testimony, dated January 8, 2004.
- Exhibit 14: Petitioners' Designation of Testimony (with excerpts of testimony index and portions of Exhibits 15 – 19<sup>2</sup>), dated January 6, 2004.
- Exhibit 15: Randy Huyck deposition (Good Samaritan) (10/23/03).
- Exhibit 16: Randy Huyck deposition (Evergreen) (11/12/03).
- Exhibit 17: Karen Nidermayer deposition (Good Samaritan) (10/20/03 and 10/21/03).
- Exhibit 18: Karen Nidermayer deposition (Evergreen) (11/12/03).
- Exhibit 19: Janis Sigman deposition (Evergreen) (11/12/03).
- Exhibit 20: Attachment 20 – Open Heart Surgery Forecasts by HSA I Average Use Rates.
- Exhibit 21: OHSD Document prepared by Karen Nidermayer (revised) 6/30/98.
- Exhibit 22: Northwest Hospital – University of Washington certificate of need analysis, dated May 16, 1997.
- Exhibit 23: Appendix I – Open Heart Surgery Need Methodology per WAC.

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<sup>2</sup> This exhibit included an excerpt of Ms. Benedict's cross examination of Karen Nidermayer from the Good Samaritan proceeding, Docket No. 03-07-C-2002CN, on December 8, 2003. Given that the Good Samaritan record was made a part of this hearing record, this two-page document was not offered or marked as a separate exhibit.

- Exhibit 24: St Mary Medical Center certificate of need analysis, dated July 21, 1997.
- Exhibit 25: Central Washington Hospital certificate of need analysis, dated February 19, 1999.
- Exhibit 26: OHSD document prepared by Karen Nidermayer (revised) 9/28/92.
- Exhibit 27: Kadlec Medical Center – Kennewick General Hospital certificate of need analysis, dated February 6, 1998.
- Exhibit 28: Kadlec Medical Center – Kennewick General Hospital certificate of need settlement analysis, dated November 5, 1999.
- Exhibit 29: Open Heart Surgery Projections prepared by Karen Nidermayer, dated October 6, 1999.
- Exhibit 30: Mary Bridge Children's Hospital – Tacoma General Allenmore Hospital certificate of need application, dated March 13, 2000. Denied on grounds of relevance.
- Exhibit 31: Withdrawn.
- Exhibit 32: Open Heart Surgery Projections prepared by Karen Nidermayer (revised), dated 11/07/00.
- Exhibit 33: Karen Nidermayer email re: OHS data request sent December 23, 2003.
- Exhibit 34: OHSD document prepared by Karen Nidermayer, prepared 1/7/2004.
- Exhibit 35: Jody Carona Matrix of Certificate of Need Open Heart Surgery Decisions (Adult Only) 1993 –2003. Admitted on a Limited Basis.
- Exhibit 36: Overlake/Evergreen Certificate of Need Application file.
- Exhibit 37: CD-ROM disc containing open heart surgery analysis, created December 2003.
- Exhibit 38: Copy of Federal Register, Vol. 66, No. 148 (66 FR 39828).
- Exhibit 39: Copy of Department of Health Memorandum from Joe Campo to Open Heart Surgery Advisory Committee, dated August 7, 1991.

- Exhibit 40: Steps 5 and 6A per Karen Nidermayer's capacity method, prepared January 7, 2004.
- Exhibit 41: Adult Open Heart Surgery Discharges from Overlake Hospital Medical Center (CHARS) from 1994 through 2001.
- Exhibit 42: Kadlec Medical Center/Kennewick General Hospital Open-Heart Analysis (reconciliation of Step C per DOH Analysis to CHARS data provided by DOH 1996 email file).
- Exhibit 43: Harrison Memorial Hospital Open-Heart Analysis (reconciliation of Step C per DOH Analysis to CHARS data provided by DOH on CD-ROM).
- Exhibit 44: Recommended Standards and Forecasting Method for Certificate of Need Review of Open Heart Surgery Programs, Open Heart Surgery Advisory Committee, September 1991.
- Exhibit 45: Copy of Department of Health Memorandum from Joe Campo to Open Heart Surgery Advisory Committee, dated August 26, 1991.
- Exhibit 46: Summary and Analysis of Written Comments on Proposed Certificate of Need Rules on Open Heart Surgery and Nonemergent Interventional Cardiology Services, undated (ten pages).

The parties agreed to incorporate the Good Samaritan hearing record into the Overlake/Evergreen record to avoid having to repeat the testimony of witnesses presented at the prior hearing. OE RP at 6. The Petitioners reserved the right to object to portions of the Good Samaritan record, and agreed to file those objections no later than the date of filing their initial closing brief. OE RP at 7 – 8. The parties were granted permission to file briefs in lieu of closing argument. OE RP at 329 – 300; Posthearing Order No. 1. The hearing record was closed on May 3, 2004. Posthearing Order No. 2. The date for issuance of the final order was extended. Posthearing Order Nos. 3 & 4.

## HEARING

The Petitioners filed a joint application to develop and manage an open-heart surgery and elective intervention program located at Evergreen Hospital Medical Center (EHMC). AR at 1199. Overlake Hospital Medical Center (OHMC) began operating its own open-heart surgery and elective interventional program in November 1986. AR at 1210. EHMC would be the legal operator, but the Petitioners would establish a new entity, the Eastside Cardiac Care Alliance (ECCA), that would ultimately enter into an agreement with EHMC and OHMC and be responsible for the day-to-day operations of a single open-heart program operating at the two hospitals. The Petitioners anticipated joint management would include medical staffing, policies and procedures, quality assurance, professional education and community outreach. AR at 1211. To support this goal EHMC and OHMC entered into a Memorandum of Understanding. AR at 1219, 1230 – 1233.

Consistent with WAC 246-310-261(3)(d), the Petitioners initially provided that the OHMC cardiac surgeons would also staff the EHMC program, with a third surgeon to be recruited prior to the opening of the service. AR at 1246. The Petitioners did not anticipate any problems addressing the emergency needs of the service area population required under WAC 246-310-261(3)(e), and anticipated the higher risk patients would be referred to OHMC. AR 1246. In response to the Program's request for supplemental information, the Petitioners stated no contract existed but considered the employee-employer relationship of OHMC with its cardiac surgeons would ensure the availability of OHMC surgeons for emergency surgery on a 24/7 basis. AR 1451.

They set out those instances when they anticipated patient transfers, and provided a sample transfer agreement regarding emergency access. AR 1451, 1479 – 1482.

Open heart surgery (OHS) and percutaneous transluminal coronary angioplasty (PTCA) services are “tertiary health services”, which are specialized services that meet complicated medical needs of people and require sufficient patient volume to optimize provider effectiveness, quality of service and improved outcome of care.

RCW 70.38.025(14). An applicant seeking to establish a tertiary health service must apply for a certificate of need. RCW 70.38.105(4) (f); WAC 246-310-020(1)(d)(i)(E).

OHS is a specialized surgical procedure utilizing a heart-lung bypass machine.

WAC 246-310-261. OHS does not include organ transplantation. Nonemergent PTCA services are performed in institutions having an established on-site OHS program capable of performing emergency open heart surgery. WAC 246-310-262. An OHS/PTCA application must also meet the general certificate of need review criteria set forth in WAC 246-310-210 through 246-310-240. WAC 246-310-261(2).

To assist potential applicants, the Program creates an annual OHS need forecast using a seven-step methodology. WAC 246-310-261(4). The need forecast methodology calculates need using known open heart surgery volumes in the identified service area for a three year period prior to the application and calculates a current capacity figure based on that information. Relevant information is obtained from the Comprehensive Hospital Abstract Reporting System (CHARS), a database containing information on all surgeries reported by all hospitals within the state. GH RP at 21 – 22.

Open heart surgery codes or diagnostic related groupings (DRG 104 - 109<sup>3</sup>) identify the relevant OHS surgeries. GS RP at 22. The CHARS data from the relevant three-year period is used to forecast open-heart surgery service needs four years after the concurrent review process (for example, a 1992 review forecasts 1996 need).

WAC 246-310-261(4)(a) through (g); WAC 246-310-261(5)(c).

Karen Nidermayer, a Health Services Consultant 3 with the Certificate of Need Program, was the lead analyst for the OHS/PTCA joint application filed by the Petitioners and their application was filed during the same concurrent review cycle as the Good Samaritan application. OE RP at 61. Ms. Nidermayer analyzed the application using the WAC 246-310-261 methodology. OE RP at 62. In Appendix A to the analysis (calculated using the "highest year" approach) the need forecast was for an additional 529 open-heart surgeries. OE RP at 62. However, in the body of the analysis itself, Ms. Nidermayer projected a net need of 492 OHS surgeries for the 2006 forecast year (calculated using the "highest age" approach). AR at 2109. As the forecast need figure was greater than the 250 OHS minimum volume figure, Ms. Nidermayer did not deny the Petitioners' application on this basis.

At the hearing for both Good Samaritan and the Petitioners, Ms. Nidermayer sought to correct the OHS methodology by substituting the "highest hospital" for the "highest age" approach. OE RP at 62 – 63. By way of background, when Ms. Nidermayer began with the Certificate of Need Program she approached Joe

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<sup>3</sup> WAC 246-310-261(5)(e) specifies that only the diagnostic related surgery codes identified in DRG 104 – 108 are to be considered for open-heart surgery purposes. It is unclear from the testimony why the Program includes DRG 109.

Campo for guidance on how to calculate current capacity for purposes of completing a forecast methodology analysis. He advised her to ignore the "highest hospital" language in WAC 246-310-261(5)(b) and use a "highest age" calculation instead, as the highest age figures were more readily available from CHARS statistical data at that time. GS RP at 85 – 87. Ms. Nidermayer subsequently used this "highest age" figure to calculate current capacity when analyzing OHS application.<sup>4</sup>

In addition to correcting the forecast methodology from the "highest age" to the "highest hospital" approach, Ms. Nidermayer sought to include the 255 OHS procedures Harrison Memorial Hospital projected it would perform under its application. OE RP at 63; see Exhibit 12. These two corrections to the current capacity calculation methodology changed the projected need from an additional 492 OHS services in 2006 to a surplus of 130 OHS services for forecast year 2006. OE RP at 63; see Exhibit 2 (the actual forecast OHS surplus figure was 137). This surplus need figure shows there is no additional OHS need existed for HSA 1 and the Petitioners' application should be denied on that ground. OE RP at 64.

As previously noted, Ms. Nidermayer found sufficient need existed to support at least one new OHS program in her analysis, and lack of need was not the basis for her decision denying the Petitioners application. Her denial decision was based on the Petitioners failure to meet the WAC 246-310-261(3)(c) standard. Ms. Nidermayer determined approval of an OHS program at EHMC (one of the Petitioners) would act to

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<sup>4</sup> The Overlake/Evergreen expert, Jody Carona, asserted at hearing that the CHARS data system has consistently allowed the retrieval of "highest hospital" information during the relevant time period. GS RP at 494.

reduce OHMC's program below the minimum 250 OHS volume standard and would also prevent another OHS facility, Northwest Hospital, from reaching its 250 minimum standard. OE RP at 65; AR at 2110 – 2115. While Northwest Hospital's OHS case level for 2001 was already below the minimum 250 OHS standard, she decided that EHMC recapturing its eight verified OHS cases would act to further reduce Northwest Hospital's OHS figure from 154 to 146 OHS procedures. Ms. Nidermayer interpreted the WAC 246-310-261(3)(c) standard required an existing facility's OHS cases not be further reduced by a new OHS application, even though that facility was already below the 250 OHS minimum standard. OE RP at 71.

The Petitioners verified EHMC referred 278 OHS patients to seven of the twelve OHS facilities in HSA 1 and contended the establishment of the new OHS facility would not reduce any of the other facilities below the minimum standard. Their conclusion was based upon total volumes of HSA 1 hospitals and the number and percentages of these volumes generated by Eastside residents. AR 1244 – 1245; AR 2111 – 2115.

Ms. Nidermayer rejected the Petitioners approach. AR at 2113 – 2115. She rejected the approach, in part, because EHMC included out of state OHS cases in its calculation and the out of state case numbers were not predictable and should not be included in the calculations. After adjusting the figure by removing the nine out of state cases, EHMC's recapture of cases it referred to OHMC would reduce OHMC's volume to 244 cases or less than the 250 OHS minimum. Additionally, Ms. Nidermayer concluded EHMC would recapture OHS cases from Northwest Hospital, with the effect that it would reduce Northwest Hospital's volume (already below the 250 OHS

minimum) even further. Finally, Ms. Nidermayer concluded the Petitioners approach did not really show any impact on other facilities. It was irrelevant to EHMC's referral patterns, so it was not helpful in determining the impact on the existing providers. OE RP at 77.

In analyzing whether the Petitioners' application would reduce the OHS volumes for any of those seven facilities, Ms. Nidermayer found eighty-one percent of the EHMC referrals were made to two facilities, Swedish Medical Center and OHMC (its co-applicant). AR at 2111. Using a simple mathematical calculation, she determined that if EHMC recaptured 100% of its referrals to those two facilities then the Petitioners' application would cause OHMC to be reduced below the 250 OHS minimum procedures. Use of the 100% recapture rate was consistent with her approach in previous OHS application analyses, including her approach in the Good Samaritan application.

After denying the Petitioners' application for failing to comply with the WAC 246-310-261(3)(c) standard, Ms. Nidermayer applied a regression analysis to determine the projected number of OHS procedures to be performed for the health service area and the state. AR at 2114 – 2115. Neither the health service area nor the state regression analysis formed a part of her decision to deny the application, but Ms. Nidermayer chose to include them in the evaluation.<sup>5</sup>

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<sup>5</sup> It is unclear from the analysis why Ms. Nidermayer included material in her evaluation/analysis when it was not used in making the ultimate decision. If it was included to address an issue or concern raised in the application record, no specific reference to the record was identified in the analysis.

Ms. Nidermayer was unable to determine if the Petitioners' application complied with the WAC 246-310-261(3)(d) standard relating to the availability of board certified cardiac surgeons. She found no contract existed between EHMS and a cardiac entity to provide for cardiology services. AP 2115 – 2116. Ms. Nidermayer concluded the executed Memorandum of Understanding did not provide sufficient information for that purpose. AP at 2116. While the Petitioners did provide a sample transfer agreement, the Program concluded it did not contain sufficient information to allow a determination if the Petitioners' program would comply with WAC 246-310-261(3)(e).

Gary Bennett, the Program's director of facilities and services licensing, denied the Petitioners application based on Ms. Nidermayer's analysis. His normal practice is to rely on the expertise and determinations made by the analysis. OE RP at 24 – 25. Any review and analysis of an OHS application is based upon the relevant statutes and regulations. Staff and applicants may also refer to prior OHS written determinations, as there is no written policy manual on how to apply any specific methodology for calculation of need. OE RP at 23 – 24. The Program's goal is to ensure and maintain a consistent approach in reviewing applications. Mr. Bennett notes the Program would not continue to apply any methodology it knows to be incorrect simply to be consistent with its past decisions. OE RP at 36.

Following her employment with the Certificate of Need Program, Jody Carona created a consulting firm in 1981, Health Facilities Planning and Development, which has participated in five open-heart surgery applications since the 1992 rule change. This includes the OHS application by the Petitioners.

The open heart surgery rule was last amended in 1992, and Ms. Carona participated on a technical advisory subcommittee to develop a forecast methodology. OE RP at 225. One issue discussed by the subcommittee was how to calculate capacity. Four different approaches were considered. OE RP at 227 – 228. Three of the four approaches identified were the highest year (selecting the calendar year with the highest OHS volume from the three year calendar period), highest age (the total of the highest OHS age-specific use rate amounts from each of the three calendar years within the period) and highest hospital (the total of the highest OHS volumes from each of the facilities within the three year period). The subcommittee found none of the approaches was considered empirically superior to the other. OE RP at 228.

Ms. Carona described capacity as the maximum amount of throughput volume the existing provider could accommodate. OE RP at 229. From a policy standpoint, she believes using the highest hospital approach allows for a significant overstatement of capacity, as a one-year spike in a hospital's figures allows for the overstatement of capacity. OR RP at 234 – 235. According to statistician Nayak Pollisar, Ph.D., the highest hospital approach is a worst case interpretation, as it is unlikely that the maximum number across the board for each hospital will be achieved. GS RP at 236 – 237. Ms. Carona considers the highest year calculation as the most reasonable approach.

Nonemergent PTCA procedures and all other nonemergent interventional cardiology procedures shall be performed in institutions which have an established on-site OHS program capable of performing emergency open heart surgery.

WAC 246-310-262. Since its joint application was not consistent with the criteria in WAC 246-310-261, the Petitioners' application for PTCA services was denied.

AR 2122.

Because the Petitioners' application was not consistent with the standards under WAC 246-310-261(3), the Program found it was not consistent with the requirements under the general certificate of need requirements under WAC 246-310-210 through 246-310-240. AR at 2123 – 2134. In deposition, and again at hearing, Ms. Nidermayer stated if the Petitioners met the WAC 246-310-261 requirements she would find the Petitioners met the general CON requirements. Exhibit 18; OE RP at 172 – 173.

### **LEGAL ANALYSIS**

The Department of Health is authorized and directed to implement the certificate of need program. RCW 70.38.105. "The [Certificate of Need] program seeks to control costs by ensuring better utilization of existing institutional health services and major medical equipment. Those health care providers wishing to establish or expand facilities or acquire certain types of equipment are required to obtain a CN, which is a nonexclusive license." *St. Joseph Hospital and Health Care Center v. Department of Health*, 125 Wn.2d 733, 735 – 736 (1995). Reduced to its simplest terms, the Program controls health care costs by granting or denying of a certificate of need application. An OHS applicant must show it complies with the need methodology requirements under WAC 246-310-261(4), the standards under WAC 246-310-261(3) and the general need requirements under WAC 246-310-210 through 246-310-240.

The Program initially found additional OHS need existed in Health Service Area 1 in the 2006 forecast year and it did not deny the Petitioners' application for this reason. The Program denied the Petitioners' application because it failed to comply with three of the standards contained in WAC 246-310-261(3). First, granting the Petitioners' application for an OHS program at EHMC would act to reduce OHMC and Northwest Hospital's OHS volume below the minimum volume standard under subsection (3)(c).<sup>6</sup> Second, in its applications the Petitioners failed to demonstrate it would have at least two board certified cardiac surgeons as required under subsection (3)(d). Finally, the Program found the Petitioners did not have a sufficient plan for facilitating emergency access under subsection (3)(e). The Petitioners disagreed with the Program's analysis on these issues and appealed the decision.

In its remand motion, and at hearing, the Program sought to correct the methodology it used to calculate need in the analysis. It argued WAC 246-310-261(5)(b) required the calculation of current capacity using the highest hospital, rather than the highest age, approach. It also argued the clear language of WAC 246-310-261(4)(a) required the inclusion of 255 OHS assumed volume from Harrison Memorial Hospital in its calculations. If need was calculated using this approach it would reveal surplus OHS capacity existed in the forecast year and the Petitioners' application should be denied on those grounds. The Petitioners dispute the Program's current capacity calculations were a "mistake". They argue the Program

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<sup>6</sup> In its post hearing brief the Program conceded that using OHS surgeries on out of state patients could be used in the calculations, and no longer claimed that the Petitioners' proposed program would fail to comply with WAC 246-310-261(3)(c) by reducing OHMC surgeries below the minimum standard. Program Post Hearing Brief, at 12 – 13.

must use the highest age method, a method it has consistently used in reviewing previous OHS applications. The Petitioners argue by its consistent use of the highest age method, the Program is now estopped from using the highest hospital method absent the amendment of WAC 246-310-261(5)(b) following the required APA rule making process.

The same issues were recently addressed in the case *In re Good Samaritan Hospital*, Docket No. 03-07-C-2002CN (July 16, 2004) (*Good Samaritan*). In that decision the Presiding Officer held:

1. The plain language of WAC 246-310-261(5)(b) defines "current capacity" using the highest hospital approach rather than the highest age or highest year approaches.
2. The Harrison Memorial Hospital OHS program capacity must be included in any calculation of current capacity.
3. The Program is not estopped from using the correct current capacity approach even though it previously used an incorrect (highest age) approach in analyzing previous OHS applications.

*Good Samaritan*, at 26 – 29. Based on the reasoning of that decision, current capacity must be calculated using the highest hospital approach. As the adjudicative proceeding does not supplant the certificate review process, the matter should be remanded to address this issue.

The Petitioners argue granting its application will not reduce OHMC and Northwest Hospital's programs below the WAC 246-310-261(3)(c) minimum standard. The Program now agrees with the Petitioners that granting its application would not reduce the number of OHMC's open heart surgeries below the minimum standard. Program Post Hearing Brief, at 13.

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The parties disagree whether reducing Northwest Hospital's open heart surgery numbers from 151 to 143 would cause the Petitioners' program to fail to comply with WAC 246-310-261(3)(c). The Program argues its interpretation is correct because the Petitioners proposed program undeniably would reduce the Northwest Hospital volume. Program Post Hearing Brief, at 13. The Program argues laws should be construed to effectuate statutory intent (i.e., preventing an OHS provider from reaching the 250 OHS minimum standard has the same effect as reducing it below the standard) and laws should be construed to avoid unlikely, absurd or strained consequences. Program Brief, at 13 (case citations omitted). The Program argues its interpretation (falling within its area of expertise) should be given substantial weight. Id.

The language of WAC 246-310-261(3)(c) provides "no new program shall be established which will reduce an existing program below the minimum volume standard." The minimum standard, pursuant to WAC 246-310-261(3)(a), is 250 OHS procedures. Since its application did not reduce Northwest Hospital below the minimum standard (as it was already approximately 99 to 107 surgeries below the OHS minimum standard), the Petitioners argue their application does comply with the language of the regulation. Petitioners' Initial Post Hearing Brief, at 12 – 14.

WAC 246-310-261(3)(c) states "no new program shall be established which will reduce an existing program below the minimum volume standard." The Petitioners argue the regulation is plain on its face and unambiguous, and therefore must be given its plain and obvious meaning. Petitioners' Initial Post Hearing Brief, at 12 (case citation omitted). The Program disagrees. In reviewing the WAC 246-310-261(3)(c), the

language of that subsection does not specifically address the issue in question, that is how to address an OHS facility which is already below the 250 OHS minimum standard.

A court interpreting a statute must first determine whether the statute's language is ambiguous, that is one whether the language is capable of more than one reasonable interpretation. *Gorman v. Garlock, Inc*, 121 Wn.App. 530, 541 (citations omitted). The question is whether WAC 246-310-261(3)(c) has more than one reasonable interpretation. Each party provides what it considers a reasonable interpretation.

In interpreting WAC 246-310-261(3)(c), the Program appears to distinguish between those situations where an existing program's surgical numbers are below the 250 OHS minimum standard and the new program does not recapture any OHS procedures from that existing program (see Exhibit 12) or where, as here, the new program does recapture OHS procedures from the existing program. The Petitioners contend WAC 246-310-261(3)(c) applies only in those situations where a new provider reduces an existing provider's OHS procedure level below the 250 OHS procedure level. In the event the existing provider is currently performing below the 250 OHS minimum level, the regulation does not apply (or reduce the existing program), even if the new program recaptures OHS procedures from that existing provider.<sup>7</sup> Were the Presiding Officer to read WAC 246-310-261(3)(c) independent of the remaining sections of chapter 246-310 WAC, the Petitioners argument would carry greater weight.

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<sup>7</sup> A review of chapters 70.38 RCW and 246-310 WAC does not reveal that the Program has any authority, once a certificate of need is awarded to a provider, to "close down" an OHS program that does not meet the 250 OHS minimum standard. It is unclear to the Presiding Officer why that authority does not exist, given that the 250 OHS procedure standard is deemed necessary to maintain OHS surgical competency levels.

The primary goal of the statutory construction is to carry out legislative intent. *Cockle v. Department of Labor & Industries*, 142 Wn.2d 801, 807 (2001). In determining legislative intent, a court must consider the entire sequence of all statutes related to the same subject matter. *Boise Cascade Corp. v. Washington Toxics Coalition*, 68 Wn.App. 447, 455 (1993). The legislative intent in chapter 70.38 RCW, in relevant part, is to develop health services in a planned, orderly fashion, consistent with identified priorities and *without necessary duplication* or fragmentation. RCW 70.38.015(2) (Emphasis added). It is necessary to give effect to all of the statutory language in construing a statute so that no portion is rendered meaningless or superfluous. *Davis v. Department of Licensing*, 137 Wn.2d 957, 963 (1999).

Open heart surgery programs are required to perform a minimum of 250 OHS procedures per year. WAC 246-310-261(3)(a). Open heart surgery, a tertiary health service, requires sufficient patient volume to optimize provider effectiveness, quality of service and improve outcomes of care. WAC 246-310-261-010. An OHS program shall meet the general standards in WAC 246-310-210 through 246-310-240 in addition to the specific open-heart surgery standards in order to receive a Certificate of Need. WAC 246-310-261(2). The population to be served must have a need for the services of the type proposed and the services are not or will not be sufficiently available or accessible to meet that need. WAC 246-310-210(1). The accessibility of such health services includes assessing the efficiency and appropriateness of the use of existing services and facilities similar to those proposed. WAC 246-310-210(1)(b).

The Program's practice of considering OHS program which are currently below the 250 OHS standard appears to include situations where (as here) a new provider recaptures OHS surgeries from an existing, but below standard, OHS provider. This reduces that existing provider's ability to maintain or achieve sufficient patient volumes and affects that provider's effectiveness. Where a new provider does not recapture any OHS surgeries from an existing, but below standard, OHS provider, that provider's ability to maintain or achieve sufficient patient volumes and effectiveness are not affected. Under that analysis, the Program's interpretation of WAC 246-310-261(3)(c) appears the more appropriate approach.

The Program determined it could not conclude whether the Petitioners complied with the WAC 246-310-261(3)(d) and (3)(e) standards. After reviewing the documentation contained in the Petitioners' application, the Presiding Officer agrees. On remand the Petitioners should be allowed additional time to provide documentation in support of these two requirements.

As stated in the Good Samaritan matter, the certificate of need adjudicative proceeding is not to supplant the certificate of need review process but to assure that the procedural and substantive rights of the parties have been observed and that the factual record supports the Program's analysis and decision. *See Ear, Nose, Throat and Plastic Surgery Associates*, Docket No. 00-09-C-1037CN (April 17, 2001), Prehearing Order No. 6, at page 8. For that reason the matter will be remanded so the Program can correct its analysis, and/or the Petitioners can supplement their application, consistent with this decision.

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## **I. FINDINGS OF FACT**

1.1 The Petitioners submitted a joint application to establish OHS/PTCA services in Health Service Area I in August 2002. Analysis of this application was assigned to Program analyst Karen Nidermayer.

1.2 In Appendix A to the analysis, the 2006 projected need for additional OHS services was calculated to be 529 additional OHS procedures. Current capacity for this projection was calculated using the highest year approach and did not include the estimated OHS volumes for the Harrison Memorial Hospital application granted by the Program in November 2001.

1.3 In the body of the analysis Program analyst Karen Nidermayer used the highest age, rather than the highest year, approach when calculating current capacity. She projected a net need of 492 additional OHS surgeries in forecast year 2006. In calculating this net need figure she did not include the estimated OHS volume for the Harrison Memorial Hospital application granted by the Program in November 2001.

1.4 The Program made two mistakes in calculating "current capacity". It used the "highest age" rather than the "highest hospital" approach required under WAC 246-310-261(5)(b). The Program did not include the Harrison Memorial Hospital OHS assumed volume in calculating current capacity required under WAC 246-310-261(4)(a).

1.5 Utilizing the "highest hospital" approach, and calculating current capacity to include Harrison Memorial Hospital's assumed volume, results in a surplus OHS capacity of 137 surgeries for health service area 1 for the 2006 forecast year.

1.6 In the absence of need for additional OHS capacity, the Petitioners application failed to meet the PTCA requirements under WAC 246-310-262, and the general certificate of need requirements under WAC 246-310-210 through 246-310-240.

1.7 Granting an OHS application to EHMC reduces the minimum OHS volume for Northwest Hospital from 151 to 143 surgeries.

1.8 A review of the Petitioners' application does not provide sufficient information to determine whether they complied with the WAC 246-310-261(3)(d) and (3)(e) requirements.

## II. CONCLUSIONS OF LAW

2.1 The Department of Health is responsible for managing the certificate of need program under chapter 70.38 RCW. WAC 246-310-010. An applicant denied a certificate of need has the right to an adjudicative proceeding. WAC 246-310-610(1); RCW 34.05.413(2). A certificate applicant contesting a Department decision must file a written application for a proceeding within twenty-eight days of receipt of the department's decision or reconsideration. WAC 246-310-610(3). Chapters 34.05 RCW and WAC 246-10 govern the proceeding.<sup>8</sup>

2.2 The Petitioners filed a joint certificate of need application to establish OHS/PTCA services in health service area 1. The application was denied on May 27, 2003, and the Petitioners appealed the Program's decision denying their application on June 24, 2003. The Petitioners' request was timely.

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<sup>8</sup> WAC 246-310-610(3) provides chapter 246-08 WAC governs the proceeding. 246-10 WAC has replaced chapter 246-08. WAC 246-10-101(3).

2.3 The burden of proof in certificate of need cases is preponderance of the evidence. WAC 246-10-606. In all cases involving an application for licensure, the applicant shall establish it meets all applicable criteria. WAC 246-10-606. Evidence should be the kind upon which reasonably prudent persons are accustomed to rely in the conduct of their affairs. RCW 34.05.452(1); WAC 246-10-606.

2.4 To be granted a certificate of need, an open-heart surgery program shall meet the standards in [WAC 246-310-261] in addition to applicable review criteria in WAC 246-310-210 through WAC 246-310-240. WAC 246-310-261(2).

2.5 A planning area's current capacity for open-heart surgery equals the sum of the highest reported annual volume for each hospital within the planning area during the most recent available three years. WAC 246-310-261(5)(b). In those planning areas where a new program is being established, the assumed volume of that institution will be the greater of either the minimum volume standard or the estimated volume described in the approved application and adjusted by the department in the course of review and approval. WAC 246-310-261(4)(a).

2.6 WAC 246-310-261(5)(b), as written, requires current capacity as the highest reported annual volume for each hospital, and requires the use of the "highest hospital" method in calculating that number. *In re Good Samaritan Hospital*, 03-07-C-2002CN (July 16, 2004). That number is then used to calculate step one of the forecast need methodology under WAC 246-310-261(4). Because the Program did not use the "highest hospital" method to calculate current capacity, it failed to correctly calculate the OHS forecast need amount for the 2006 forecast year.

2.7 WAC 246-310-261(4)(a) requires the calculation of current capacity include the minimum or estimated volume of a new program where such program is being established. A new program (Harrison Memorial Hospital) was established in 2001 after the Petitioners application was filed and should have been used in calculating current capacity. The Program failed to do so and therefore did not correctly calculate current capacity in analyzing this application.

2.8 The language in WAC 246-310-261(5)(a) is unambiguous and requires calculation of current capacity using the "highest hospital" method. The language in WAC 246-310-261(4)(a) is unambiguous, and requires the calculation of current capacity using the 255 OHS assumed volume of Harrison Memorial Hospital. Because the regulation is unambiguous it is not subject to the rules of statutory interpretation, and must be applied by the Program as written. Because the issue raised on appeal speaks to a matter of law rather than an issue of fact, the Program is not estopped from correctly applying the language of the relevant regulation.

2.9 WAC 246-310-261(3)(c) provides no new OHS program shall be established which will reduce an existing program below the minimum volume standard. The regulation does not specifically address the situation where an existing program is currently performing below the 250 OHS minimum standard. The regulation is therefore ambiguous and subject to the rules of statutory interpretation.

2.10 Based on the legislative intent contained in RCW 70.38.015(2), and interpreting WAC 246-310-261(3)(c) in conjunction with the other regulatory sections contained in 246-310 WAC, an applicant can reduce the OHS volume of an existing

program, even though the existing program's OHS volume has not achieved the 250 OHS minimum standard. By reducing Northwest Hospital's OHS standard from 151 to 143, the Petitioners application fails to comply with the WAC 246-310-261(3)(c) standard.

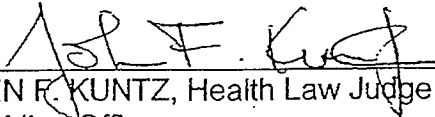
2.11 The language of WAC 246-310-261(3)(d) provides an OHS program shall have at least two board certified cardiac surgeons, at least one of whom is available for emergency surgery twenty-four hours a day. WAC 246-310-261(3)(e) provides that institutions with OHS program shall have plans for facilitating emergency access to open heart surgery services at all times for the population they serve.

2.12 Based on a review of their application, and supplements to that application, there is insufficient evidence to determine whether the Petitioners meet the standards contained in WAC 246-310-261(3)(d) and (3)(e).

### III. ORDER

Based on the foregoing Procedural History, Findings of Fact and Conclusions of Law, the Certificate of Need Program's determination denying the Petitioners' open-heart surgery application is REVERSED and the application REMANDED to the Program for processing consistent with the terms of this Order. The recalculation shall be filed with the Adjudicative Service Unit within 28 days of the date of service of this order.

Dated this 20<sup>th</sup> day of August, 2004.

  
JOHN F. KUNTZ, Health Law Judge  
Presiding Officer

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### NOTICE TO PARTIES

This is not a final order issued under RCW 34.05.461. A final order based upon these Findings of Fact shall be issued after receipt of the recalculation completed in accordance with this order.

The recalculation shall be filed with the Adjudicative Service Unit within 28 days of the date of service of this order. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This Order was "served" upon you on the day it was deposited in the United States mail. RCW 34.05.010(19).